

BULLETIN

AMERICAN COLLEGE OF SURGEONS



May 2002
Volume 87, Number 5

SEPTEMBER 11, 2001:

A test of
preparedness
and spirit



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About the cover...

The September 11, 2001, attacks on the World Trade Center and the Pentagon tested the preparedness and spirit of all Americans, but none needed to rise to the challenge so dauntlessly as the physicians, hospitals, police officers, firefighters, and others who had to directly cope with the situation at hand. This month's cover story (p. 12-17) describes how the staff at St. Vincent's Hospital in Manhattan, NY, readied the facility for the potential onslaught of victims rescued from the nearby towers.

The experience at the Pentagon will be featured in a future issue of the *Bulletin*.

Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000, fax: 312/202-5001; e-mail: postmaster@facs.org; Web site: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

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Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

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From my perspective

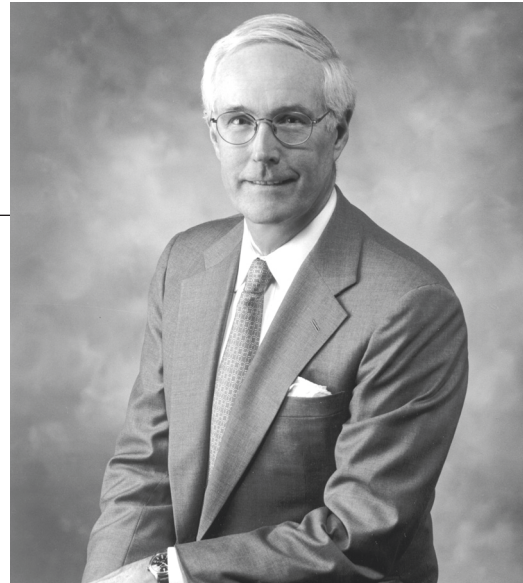
Earlier this year, I had the rare privilege of presenting the Digby Memorial Lecture during the Hong Kong Surgical Forum, and I addressed some of the issues related to the globalization of surgical care and the role that the American College of Surgeons can play in it. I thought it might useful to share some of those comments with you.

The effects of globalization

At almost lightning speed and without geographic barriers, we can now conduct business and spread information. With great rapidity, nations have signed trade treaties, the World Trade Organization has developed, and globalization has spread astronomically. Trade and foreign asset ownership have reached new heights relative to world income, and the Internet has facilitated low-cost communication around the world.

However, as U.S. Counsel General to Hong Kong Michael Klosson said during a speech to the Hong Kong General Chamber of Commerce, “These same factors have also made us all more vulnerable to some of our oldest problems.” Among these difficulties, he notes, are terrorism, the spread of disease, cultural conflicts, disruption of the natural environment, and the growing gap between developed and developing lands.¹ C. Rollins Hanlon, MD, FACS, former Director of the College and a Consultant to me, said it well more than a quarter of a century ago during the opening ceremonies of the Third Congress of the Collegium Internationale Chirurgiae Digestivae: “The economic unity of our planet and the fearsome interdependence of have and have-not nations has suddenly become abundantly clear to all of us.”² At that time, Dr. Hanlon was referring to our dependence on other countries for fossil fuels.

In light of recent events, Dr. Hanlon’s words resonate more thunderously than ever. Places like North America and Hong Kong generally have been fortunate. We have strong free market economies and have enjoyed many of the fruits of globalization. Exactly how much good globalization holds for countries with limited



“It is our professional obligation as surgeons to determine how we can best ensure that all countries—rich or poor, powerful or powerless—reap the medical benefits that can be experienced as a result of the progress being made.”

resources remains debatable. Some experts say that globalization has led to increased financial stability for developing countries, such as China, Vietnam, and Uganda. This increased financial security has led to better nutrition, lower infant mortality, improved prenatal care, and enhanced health education.³ Others claim that globalization has outpaced the ability to grow and change within Eastern Europe, Africa, and Latin America. In fact, some people say these countries have actually fallen behind in terms of economic stability and the provision of social services. As a result, the overall health status of the people in those regions has suffered.⁴

Regardless of which view is more correct, globalization is likely to stay with us for some time, and it is our professional obligation as surgeons

to determine how we can best ensure that all countries—rich or poor, powerful or powerless—reap the medical benefits that can be experienced as a result of the progress being made.

Worldwide partnerships

I propose that the U.S. and other economically developed countries work together to overcome the challenges before us and to ensure that medicine does, in fact, lead to improved health care conditions for all humanity. Specifically, we could form alliances to advance globalized scientific research and to combat one of the world's most threatening problems—bioterrorism.

Partners in research

Many developed countries have been making concerted efforts to determine how best to improve quality of care and apply evidence-based medicine in providing surgical and other medical services to aging populations. In the U.S., the National Institutes of Health and the Agency for Healthcare Research and Quality (AHRQ) are looking to the medical and surgical communities to help them determine which treatments are most effective and lead to the best outcomes. Hence, about three years ago, the ACS established the American College of Surgeons Oncology Group (ACOSOG), which has been conducting clinical trials for treatment of a range of malignant neoplasms.

More recently, we established a Division of Research and Optimal Patient Care, which houses an Office of Evidence-Based Surgery. This office and division will be critically important in the future with regard to evaluating data. They will assist in determining best practices and the potential for clinical trials even beyond what we are currently accomplishing through ACOSOG. There are a multitude of other topics this division could effectively evaluate in the coming years. I would like to think that opportunities will arise in the not-too-distant future for the College and other international organizations to at least share the information that emerges from these studies and perhaps conduct cooperative studies on issues of mutual concern.

Partners against bioterrorism

Another issue that should be on the agendas of all countries at this time is terrorism. As Federal Reserve Chairman Alan Greenspan recently said, "Terrorism poses a challenge to the remarkable record of globalization.... If we allow terrorism to undermine our freedom of action, we could erase at least part of the palpable gains achieved by postwar globalization. It is incumbent on us not to allow that to happen."⁵

Our struggle against the horrors of international terrorism will most likely be long and arduous. As we cooperatively battle terrorism, we must remember that this type of warfare does not always involve kamikazes, bombs, grenades, and other typical combat weaponry. A more pernicious form of terrorism takes the form of strikes involving chemical and biological agents.

As I've mentioned before, the College is responding to the crisis. During the 2001 Clinical Congress, the Board of Governors and the Committee on Trauma issued two statements that reflect our willingness to contend with biologic and chemical terrorism (*Bulletin*, November 2001). As a result of the recommendations set forth in these documents, the College is considering the establishment of a network of related trauma agencies and the formation of alliances with federal, state, and local agencies.

We also could forge a bloc of international organizations to create a worldwide bioterrorism response system. The one positive side effect of the September 11 attacks on the U.S. has been that people of many backgrounds, races, cultures, and countries have united to fight terrorist networks. I anticipate that surgeons will similarly unite to defeat the potentially ravaging effects of bioterrorism.

Cross-cultural research

Ever since modern medicine really came into its own about 150 years ago, surgeons and other physicians have exchanged knowledge and skills to help overcome health care crises at home and abroad. I believe that now, too, we can be of most assistance to developing countries by stepping up scientific research. We must collect, analyze,



Dr. Russell (fifth from left) meets with the staff of the University of Hong Kong Medical Centre during his participation in the Hong Kong Surgical Forum. To the right of Dr. Russell is John Wong, MB, BS, FACS(Hon), professor and secretariat of the department of surgery at the medical center, Queen Mary Hospital. Dr. Wong invited Dr. Russell to present the Digby Memorial Lecture.

and exchange data in more global and systematic ways.⁶ The College operates two large data banks that focus on cancer and trauma. These repositories gather, sort, and disseminate U.S. hospital data for use by surgical scientists. We are looking at ways to make these databases more valuable to the research process. Perhaps we could work with international health groups, such as the World Health Organization, to develop a worldwide network of similar data banks. This type of research may lead to new medical advances for both developing countries and for developed countries with populations suffering from similar conditions.

Outreach

Another way physicians of all stripes historically have helped to resolve some of the world's plights is by working with religious and humanitarian organizations to bring medical and surgical care and training to underprivileged parts of the world. Many among us continue to provide this sort of

relief. Indeed, it is simply impossible to list all the examples of surgeons who have donated their time and skills to helping people in Africa, Asia, the Caribbean, Central and South America, and other regions with limited numbers of facilities and surgeons. These "Good Samaritans" have done much to improve the lives of many people who believed their conditions were hopeless. In return, they have often rediscovered the joy of surgery. They have had opportunities to perform many operations on patients who need and appreciate their help, and they have been able to do so largely without fear of lawsuits or the burdens of bureaucratic payment systems.

Unfortunately, few surgeons can devote more than a few weeks per year to caring for people overseas, especially when many at home often need our assistance. Hence, we must encourage more surgeons to get involved in outreach surgery. We must also find ways to ensure that surgeons who do take their skills into underserved areas leave a lasting legacy, making certain they



Guan Bee Ong, MB, BS, FACS(Hon), emeritus professor of surgery at the University of Hong Kong Medical Center (right), presents Dr. Russell with a medallion honoring his presentation of the Digby Memorial Lecture during the Winter 2002 Hong Kong Surgical Forum.

pass on their skills to the health care professionals currently practicing in underprivileged countries on a day-to-day basis.

Educational opportunities

While the provision of charitable care is a significant component in overcoming the devastating impact of operable disease in other countries, simply providing such services is not enough. I believe it is very important that we work to ensure that a more well-educated medical services workforce exists within developing countries.

The College has promoted international surgical education for many years. For example, we have traditionally offered International Guest Scholarships to competent young surgeons who have demonstrated strong interests in teaching and research. The scholarships, in the amount of \$10,000 each, provide scholars with an opportunity to visit clinical, teaching, and research institutions in North America and to attend and

participate fully in the American College of Surgeons' Clinical Congress. For the year 2002, we received a total of 78 complete applications from young surgeons all over the world, including a number of underserved countries, such as Bangladesh, Indonesia, Guatemala, and Nigeria.

Another educational program that reaches beyond the shores of North America is the Advanced Trauma Life Support® (ATLS®) program. The ATLS International Program was initiated in 1986, about eight years after we started offering the courses in the U.S. ATLS courses currently are presented in 45 countries, and approximately 350,000 physicians in countries ranging from England and Australia to Trinidad/Tobago have been trained in ATLS. ATLS serves as a prototype for the development of similar courses by other international societies for trauma training. Further, the techniques that have been used to develop and present the program could be applied to other types of care. Perhaps we could train physicians in countries that have shortages of surgeons to manage other conditions using this model.

Enhanced use of technology

Finally, we must encourage the proliferation of information and communications technology because today's high-powered computer technology can assist in improving worldwide health care on three levels—better education of health professionals, rapid exchange of ideas, and new delivery systems.

The College is doing much to enhance the ability of surgeons to obtain CME credits and to engage in lifelong learning through computerized at-home study. Some of the information exchanged at the annual Clinical Congress can now be accessed online, and individuals who want to test their understanding of clinical issues may do so through the *Journal of the American College of Surgeons*. Additionally, the College recently launched the eleventh version of the Surgical Education and Self-Assessment Program (SESAP 11), which also allows surgeons to expand and improve their knowledge and skills through in-home study.

Surgeons and surgical organizations also can use computers to more speedily disseminate information about public health issues and emergency advice. As I mentioned before, the College's Committee on Trauma is developing a plan for responding to terrorist attacks. We will publish this information on our Web site, and perhaps we could link institutions that have response plans, so they can exchange information during times of crisis. Additionally, public health organizations could post information about health problems in specific countries, and interested physicians and other practitioners could offer their expertise via the Internet.

And, of course, there is the field of telemedicine, with its ability to assist in delivering advanced surgical care to the farthest ends of the earth. Surgical organizations and professionals should contribute to this still largely untapped field, so that someday it will be possible for patients to undergo treatments that have just been developed continents away from their home.

Nonetheless, we must accept the reality that the world is now subject to what some people call "the digital divide." This term refers to the fact that only 5 percent of the world population has the financial and electronic resources to participate in the Internet and telecommunications revolution.⁶ We should work with computer companies and device manufacturers to help determine whether it is possible and worthwhile for surgeons to bring this technology to those who have been denied it for too long.

Conclusion

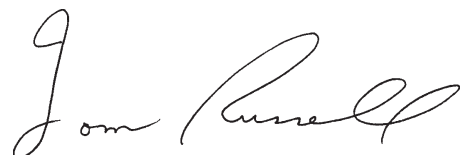
Accomplishing any of these tasks will be difficult and will require us to be ever mindful and tolerant of each country's uniqueness. As Dr. Hanlon said in his speech more than 25 years ago, "In the world of international affairs, scientific and otherwise, there are great divisive forces. There are factors of geography, of ethnic differences, of differences in temperament and tempo, and the considerable barrier of varied language."² We must accept and respect the fact that some cultures may oppose the performance of certain types of procedures and research

methods. Others may consider our efforts meddlesome and an interference with their entire way of life.

However, we have much to share, much to teach, and much to learn. I look forward to the American College of Surgeons becoming a truly international organization.

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Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

At its February 8-9, 2002, meeting, the ACS Board of Regents approved an ad hoc committee to **review the structure, composition, and terms of the Board of Regents**. The ad hoc committee has been charged with the task of addressing five specific issues: length and number of terms; retirement/resignation; public members; international members; and adequate representation (specialty, geography, diversity, and all practice venues). To review other highlights of the recent Regents' meeting, see pages 48-57 in the April 2002 issue of the *Bulletin* or visit <http://www.facs.org/news/regentsfeb2002.html>.

Thomas R. Russell, MD, FACS, ACS Executive Director, hosted a **meeting of the surgical specialty society chief executive officers and ACS Advisory Council Chairs** in Chicago on March 29. Among other issues, the group discussed the current professional liability insurance and Medicare payment crises, as well as opportunities for strengthening collaboration between all the surgical groups.

The new annual edition of the College's ***Publications and Services Catalog*** is now online. There are two ways to view and order titles from the 2002-2003 catalog. You can visit the online catalog at <http://www.facs.org/commerce/2002/catsplash> and browse through titles covering a wide range of surgical topics before placing your credit card order via a secured Web server. Or you can download and print out a paper copy of the catalog—and its corresponding order form—and then fax (312/202-5001) or mail your order to the College's customer service staff (American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211).

The Office of Continuing Medical Education of the American College of Surgeons has implemented a **CME Joint Sponsorship Program**. The program is being conducted by the College as a national accrediting organization under the Accreditation Council for Continuing Medical Education and offers cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for their CME programs and meetings. Further information and application materials are available from JSP@facs.org or online at http://www.facs.org/meetings_events/cme_events.html.

The Trustees of the American College of Surgeons Insurance Trust recently accepted a proposal from New York Life Insurance Co. for a **new 10-Year Level Term Life Insurance Plan**. The new plan offers dramatically reduced premium rates and guarantees that the rates will not change for the initial 10-year period. For details, contact the plan administrator at 1-800/433-1672, or via e-mail at usia-ac@usi-administrators.com. You can also access the Insurance Program through the College's Web site at <http://www.acs-insurance.com/>.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

OIG issues reports on ASC oversight

In late February, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued a set of reports assessing how state and federal agencies and accreditors oversee ambulatory surgical centers (ASCs). Medicare pays more than \$1.6 billion each year for services provided in approximately 3,000 ASCs, which, under program rules, must either be certified by a state survey and certification agency or be accredited by an approved private entity. Key findings in the report include the following:

- The annual volume of procedures performed in ASCs increased by more than 700 percent in the 1990s, making adequate oversight more important than ever.
- Medicare's system of quality oversight of state and private accreditation and certification procedures is not up to the task.
- Medicare does little to hold state certification agencies and accreditors accountable to the program and to the public.

The report offers a series of recommendations to strengthen Medicare's oversight standards and procedures. "Quality Oversight of Ambulatory Surgical Centers: A System in Neglect" and two supplemental reports are available on the Web at <http://oig.hhs.gov/oei/oei/html>.

CMS proposes modifications to privacy rule

HHS Secretary Tommy G. Thompson announced on March 21 that the Office of Civil Rights proposes to change previously issued health privacy regulations in order to ensure strong privacy protections and to correct unintended consequences that threaten access to quality care.

The federal privacy regulations guarantee patients full access to their medical records and give them more control over the use and disclosure of their personal information. However, Secretary Thompson noted that revisions are needed to avoid making it more difficult for patients to obtain quality care quickly and easily. More specifically, the proposed changes would:

- Strengthen notice provisions and remove prior consent requirements that could hinder access to care.
- Maintain the "minimum necessary" rule governing exchange of protected information, while clarifying that routine conversations between doctors, nurses, and others involved in a patient's care are allowed.
- Ensure appropriate parental access to their children's records.
- Prohibit the use of records for marketing.
- Eliminate the need for researchers to use multiple consent forms—one for informed consent to the research and one or more related to information privacy.

HHS first proposed federal privacy standards in 1999, with final standards published in December 2000. Early last year, HHS received more than 11,000 additional comment letters, which were reviewed and used in developing the most recent changes. Most covered entities have until April 14, 2003, to comply with the patient privacy rule. Additional information is available at <http://www.hhs.gov/ocr/hipaa>.

House leaders seek changes in pay formula

House Ways and Means Committee Chair William M. Thomas (R-CA) and Health Subcommittee Chair Nancy L. Johnson (R-CT) advised the Centers for Medicare & Medicaid Services (CMS) that they believe the 5.4 percent reduction in the 2002 Medicare physician fee schedule was achieved through “questionable assumptions and uncorrected errors.” In a March 21 letter to Administrator Thomas Scully, they insisted that the reduction was “premised on several actuarial assumptions that are at best open to debate, and at worst, specious.” Without a change by CMS, additional pay cuts have been projected at the following levels: 5.7 percent in 2003 and 2004, 2.8 percent in 2005, and 0.1 percent in 2006. Surgeons may support efforts by Representatives Thomas and Johnson through the College’s Legislative Action Center at <http://capwiz.com/facs/home/>.

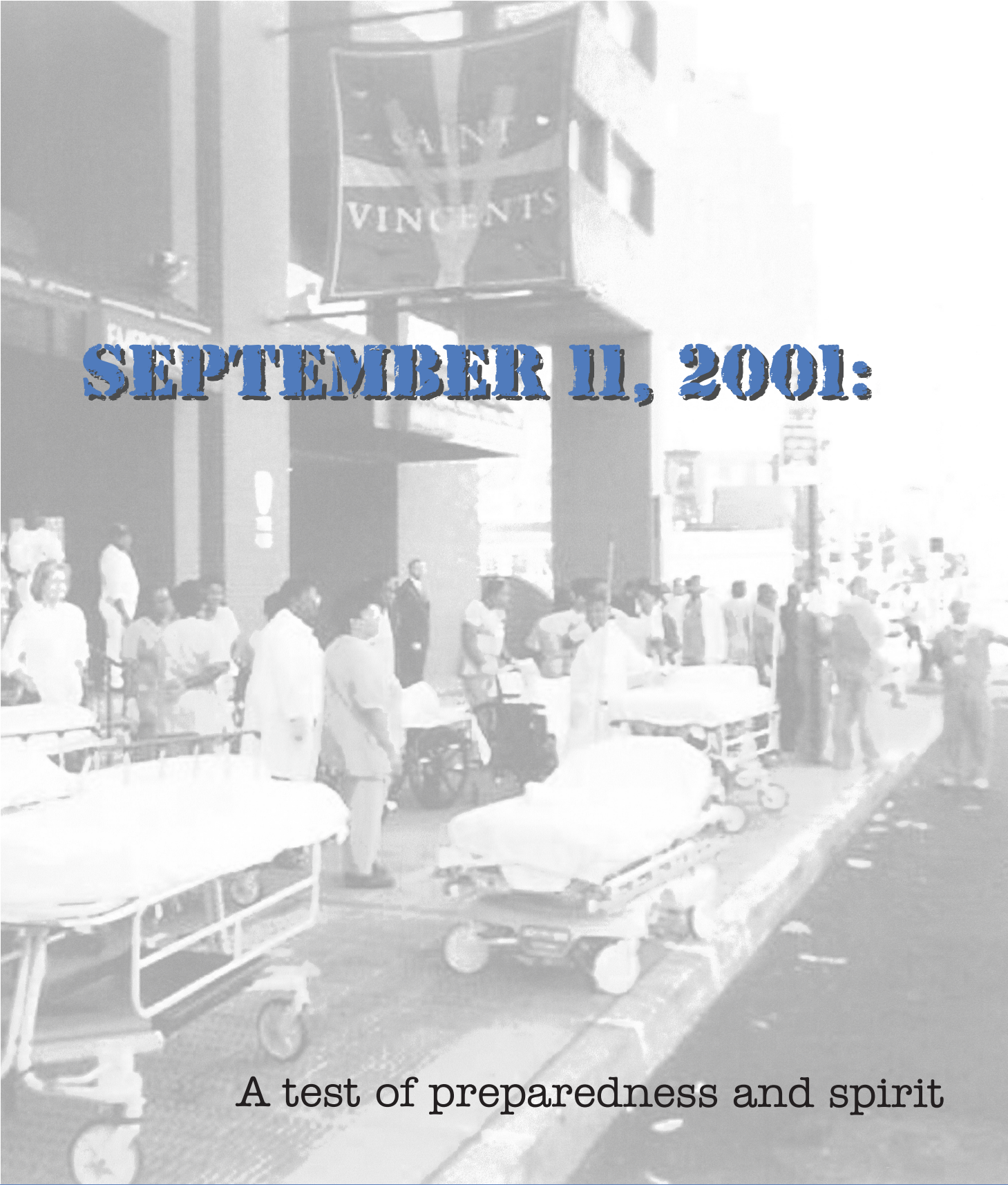
HIPAA electronic transactions extension available

CMS announced on March 29 that it was releasing its “Electronic Health Care Transactions and Code Sets Standards Model Compliance Plan,” which will allow health plans, clearinghouses, and providers to receive a one-year extension to comply with new rules governing electronic health care transactions that were mandated by the Health Insurance Portability and Accountability Act (HIPAA). Those practices that are unable to comply with the current deadline of October 16, 2002, may submit a compliance plan and request an extension online or on paper. Further information is available at <http://www.cms.hhs.gov/hipaa/hipaa2/default.asp>.

House committee hosts hearing on equitable health regulations

The House Small Business Committee hosted a hearing on April 10 to determine how improved compliance with the Regulatory Flexibility Act could ease the burdens on small-group practices. Testifying on behalf of the American Academy of Otolaryngology-Head and Neck Surgery, incoming executive vice-president, David Nielsen, MD, FACS, recounted for the congressional representatives his experience as a solo and small group practitioner. “At one point in my solo practice I counted over 55 agencies or institutions with some form of daily oversight or regulatory control over my practice. Physicians like myself share a common frustration with the barrage of burdensome Medicare regulations and guidelines and the constant struggle to remain compliant without forsaking time with our patients or our dedication to quality health care.” He also detailed the unnecessary burdens, as well as the unreimbursed costs, physicians must bear in order to comply with federal health and safety regulations.

At the same hearing, committee chair Donald Manzullo (R-IL) criticized CMS Administrator Thomas Scully for refusing to testify about how Medicare regulations may have hurt small businesses that sell medical devices, such as portable X-ray machines. Physicians had said that Medicare’s low reimbursement rates had caused several of these companies to fold. Mr. Scully ignored a committee subpoena to testify as he felt it inappropriate to be appearing on the same panel with organizations his agency regulates, especially given that they had “...gripes about a particular regulation.”



SEPTEMBER 11, 2001:

A test of preparedness and spirit

by James Feeney, MD, Nayana Parekh, MD,
Jesse Blumenthal, MD, FACS, and Marc K. Wallack, MD, FACS

As physicians and surgeons, we must be prepared to deal with the large-scale injury and loss of life left in the aftermath of natural and man-made disasters. Saint Vincent's Hospital in Manhattan, NY, had been located in the shadow of the World Trade Center since the towers were built in 1973. When the first terrorist bombing at the World Trade Center occurred, we realized that because we were the closest Level I trauma center, we needed to implement a disaster plan, which became effective February 26, 1993. That initial strike was the largest single event we had ever witnessed; we treated 160 patients, admitted 40, and performed multiple surgeries with only one death.

The experience taught us the value of a well-designed disaster contingency plan. To improve our plan, we've been holding mock disaster drills yearly, focusing on various scenarios. Additionally, we have had several actual multiple casualty events, ranging from shootings to automobile crashes to subway derailments.

The morning of September 11, 2001, however, was the single largest act of aggression against Americans on their native soil since the Civil War, leaving in its aftermath more casualties than the 1995 bombing of the Murrah Federal Building in Oklahoma City, OK, or the 1941 Japanese bombing of Pearl Harbor. It was the supreme test of our hospital disaster preparedness.

Initial reaction

At 8:50 am on Tuesday, September 11, 2001, the seven acute care hospitals of Saint Vincent's Catholic Medical Center once again implemented their disaster plan in response to a reported plane crash into one of the World Trade Center towers. Realizing that Saint Vincent's would once again serve as the central receiving hospital for casualties due to our proximity to the World Trade Center, the trauma service, headed by Jesse Blumenthal, MD, FACS, spearheaded the response to the disaster code. A

predesignated command post on the first floor of Saint Vincent's was established and staffed by department heads, senior medical and surgical staff, and local New York Police Department precincts. Medical and ancillary personnel were requested to report immediately to their preassigned positions or to the human resource pools, which comprised approximately 300 physicians, 100 nurses, and 500 other staff members. The emergency room at Saint Vincent's was designated as the admitting and triage area, and the senior surgical personnel preassigned as triage officers took their posts to await the arrival of casualties. Elective operations were immediately cancelled, and all routine functions were suspended. The operating rooms, hemodialysis unit, endoscopy suite, cardiac catheterization laboratory, and the recovery room were put on alert status, thus making available every monitored bed in the hospital for the most seriously injured patients.

Within minutes of the disaster, efforts were under way to clear the ICU and other monitored beds. Efforts to discharge, transfer, or otherwise remove patients from the emergency room continued, as did efforts to discharge patients from regular hospital beds. Security, maintenance, and public information personnel were alerted. Supplies were marshalled in predesignated areas, and record room personnel moved to the triage area with sequentially numbered disaster charts. The rehabilitation gymnasium was staffed and designated to treat minor injuries. Six overflow emergency rooms were set up and staffed. Communications between key areas were established by walkie-talkie.

Marc Wallack, MD, FACS, chairman of the department of surgery at Saint Vincent's, remembers attending his regularly scheduled morbidity and mortality conference at Metropolitan Hospital, located on 96th Street and Second Avenue. Upon hearing of a small plane crashing into the World Trade Center from his wife, Jamie Colby, a local television reporter, he returned to Saint Vincent's to oversee the disaster operations. He traversed the more than 80 blocks to the hospital in less than 15 minutes; the trip takes up to 90 minutes on a normal business day. People were stopped along the side of normally bustling Fifth Avenue, staring open-mouthed at the burning

Left: In the wake of the World Trade Center attack, Saint Vincent's emergency room staff assembles stretchers on Seventh Avenue and awaits casualties.



Surgical residents, Saint Vincent's surgical staff, and others attend to a victim of the World Trade Center disaster.

towers and walking en masse toward the disaster. The surreal spectacle was punctuated by the sight of Saint Vincent's, with trauma teams mobilized and Seventh Avenue lined with gurneys.



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As patients began coming into Saint Vincent's, we adapted our logistical response and organization based on the nature and number of injuries. As patients were admitted, the types of injuries were noted, and our space allocation, resource utilization, and supply requisitions were modified to better meet the needs of the injured patients. Personnel were reassigned and reorganized to better manage the types of injuries we saw as the day progressed.

Ready for the injured

Within three hours of the attack, Saint Vincent's had secured a two-week supply of medical and surgical items, including 25 beds, 25 ventilators, 300 oxygen tanks, 7,500 burn packs, 18,000 pieces of burn linens, and various medications. An emergency medicine team of physicians and nurses from Saint Vincent's was



Dr. Blumenthal assesses the situation at Ground Zero and relays his findings to others at Saint Vincent's. The dust particles in the air are visible in the photograph.

established to staff triage sites at the two Staten Island Ferry terminals, on board the ferry itself, at a local high school, and at Ground Zero.

The Federal Emergency Management Agency (FEMA) organized a triage center at Chelsea Piers, a warehouse and film studio complex located along the banks of the Hudson River. Vincent Scarpinato, associate program director, was stationed at the Chelsea Piers site. He remembers the day as being like "something out of a movie." The FEMA triage site was expansive, covering the floors of two large warehouses. One warehouse was designated for the treatment of medical conditions, while the other was assigned as the surgical triage area. Each treatment team was composed of a surgeon, a paramedic, a nurse, an OR technician, and a medical student or resident. The anxiety was palpable in the triage center, but by evening, the panic that set in soon after the attack had been replaced by frustration. Only a

handful of patients was seen in the FEMA triage center; it was closed the next day. According to Dr. Scarpinato, "The great sadness of that day was that the patients never came."

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NY.



Back at Saint Vincent's, because of the many serious burns, additional burn packs, burn linens, and burn medications were sent to the emergency areas. A burn unit was established on the plastic surgery floor. Otolaryngology and pulmonary medicine were mobilized to help assess and treat patients with airway, facial, and neck burns. Many minor burn patients and 15 patients with major burns were seen and treated. Four of the most seriously burned patients, some with burns covering up to 85 percent of the body surface area, were transferred to the burn center at New York Presbyterian Hospital after initial stabilization by plastic surgery personnel at Saint Vincent's. Only one early fatality occurred within this group, which was due to an inhalation injury.

Serious crush injuries, multiple fractures, and blunt trauma were also encountered in the early period after the attack due to the falling debris as well as the concussive forces of the explosions and subsequent building collapses. Debridements and closed reductions were scheduled on a staggered rotation over the next two days to maintain operating room availability. In this group, there were three fatalities due to massive blunt trauma.

Serious, unexpected logistical problems outside the hospital hampered treatment efforts inside the hospital. For example, Saint Vincent's Hospital is on the same water line as the World Trade Center. In the hours following the disaster, water pressure dropped from 130 psi to 10 psi. Within 60 minutes, however, then-Mayor Rudolph Giuliani sent two large water tanks to

supply the hospital and ensured that heating, ventilation, and air conditioning and suction equipment was available to Saint Vincent's. Computer communication lines, which were routed through the World Trade Center, were also lost initially, but by working closely with Verizon, communications were quickly rerouted and restored.

Emotional toll

New Yorkers responded to the disaster with an outpouring of volunteerism and personal sacrifice. While their services were a necessary and welcome part of the overall response to the tragedy, organizing the vast numbers of volunteers in the early hours was a daunting task. Within two hours of the attack, more than 500 blood donors had assembled outside the hospital. They arranged themselves by blood type, and Mayor Giuliani secured transportation for many of them to other sites in Manhattan, as the capacity to collect and process donated blood at Saint Vincent's was overwhelmed by the sheer number of unsolicited donors. Merchants, restaurants, and community members donated and served food to hospital staff, emergency workers, and to families and friends of victims. Numerous curiosity seekers, well-wishers, and volunteers beset Saint Vincent's, taxing the resources of the security department and creating a potential impediment to the delivery of speedy, efficient care to the injured.

By 2:00 pm, however, it was clear that those who were to survive had already escaped, and the most serious injuries had already passed through the doors of Saint Vincent's. By the end of the day, we had seen a total of 1,038 patients in the hospitals of Saint Vincent's. We had treated 797 victims, rescue workers, and volunteers; we had admitted 115 and lost four to fatal injuries in the hospital.

The emotional scars, however, were much deeper. Many employees had family, friends, and loved ones working in the World Trade Center or working for the New York Police Department, the fire department, or emergency medical services. Those individuals at Saint Vincent's who lost loved ones, and even some of the most jaded rescuers, found their normal coping mechanisms overwhelmed. The captive audience of nurses,



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patients, and residents on the upper floors of Saint Vincent's could only stand by and watch as the hulking towers first burned and then collapsed in an immense mushroom cloud of smoke. As Christopher Mills, MD, FACS, associate chairman of surgery, recalls, the morale of those who were left on the wards of Saint Vincent's to care for the inpatients was dismal. The atmosphere was one of frustration and helplessness. "In the end," he said, "[their] job was among the most difficult and important in the hospital."

Crisis counseling, pastoral care, and mental health support to victims and their families, rescue workers, and staff at Saint Vincent's started almost immediately. The New School University offered one of its buildings, located one block from the hospital, as a family center. More than 6,800 visits were made to the center, which was eventually moved to the Reiss Pavilion at Saint Vincent's. Fifty employees per shift checked the names of missing loved ones against rosters of admitted and treated patients and provided transportation if a match was found. Clinicians are still working closely with schools in southern Manhattan to provide debriefings and counseling for staff and students, including those at Public School 89, located about one block from the disaster site.

Lessons learned

Through this terrible and tragic event, we came to reaffirm our knowledge that a comprehensive disaster plan is essential in effectively dealing with large-scale casualties. Communications and logistics are difficult to establish in dire times, and must be in place before they are needed. Instant communication within the hospital is essential to safe patient flow and to access to needed supplies.

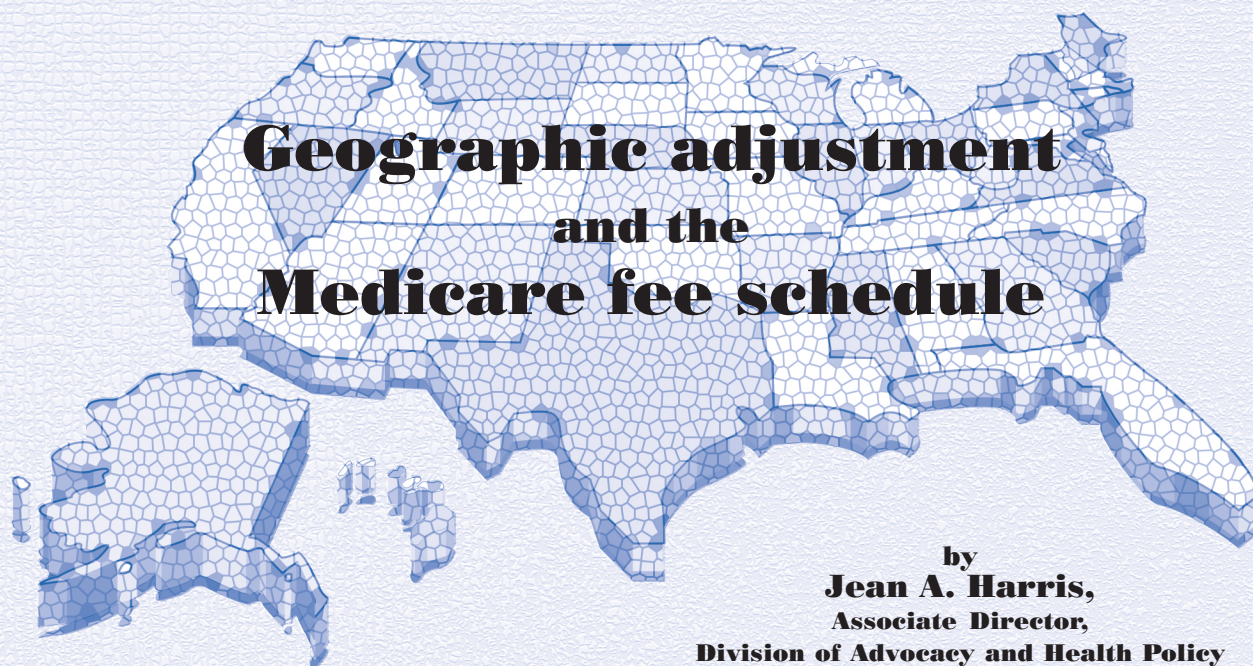
In dealing with disasters of these massive proportions, we came to realize that a pre-plan is needed to manage volunteers, blood donors, press, and curiosity seekers. Hospital security can become paramount to hospital operations, as access to the hospital may need to be controlled. We must be alert to the enormous emotional strain on family members, victims, and medical and rescue personnel, and we must be

able to deal openly with these issues. Immediate and long-term counseling must be available on both an individual and a group basis.

At 8:50 am on September 11, 2001, the faces and hearts of New Yorkers and people all over the world were turned toward the southern tip of Manhattan Island, where the colossal World Trade Center towers, which usually overshadowed the city majestically, burned furiously and filled the air with thick smoke and a pungent odor of burning metal. Saint Vincent's, the old charity hospital for the indigent, which has been quietly serving Greenwich Village since 1849, was again pressed into the service of the people of New York during one of the worst times in the city's long history. The smoke would last for weeks, the odor for months. The emotional repercussions may stretch on for decades. Efforts currently are under way to upgrade the disaster plan at Saint Vincent's, so that the lessons from the tragic attack of September 11 may last forever. □

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While the Medicare fee schedule has been in place for a decade, Fellows continue to have questions about payment differences across the country. Much of this variance has to do with geographic contrasts in practice costs. Just as the cost of living varies across the country, the cost of running a practice varies from locality to locality. This article briefly describes how the Medicare program determines and applies the geographic adjustment of payments for services around the country.

Bases of payment

Payment is based on three factors. Two of them are nationally uniform: (1) three sets of relative value units (RVUs) for a service, which represent the total value for physician work, practice expenses, and malpractice premiums; and (2) a dollar conversion factor that translates RVUs into payments. For 2002, the conversion factor is \$36.20, so, this year, each fee schedule RVU is worth \$36.20.

A third factor, called a geographical practice cost index (GPCI, which is pronounced “gypsy”) is used to adjust the payment for variations in operating costs of medical practices in different markets. Because there are three RVUs to be adjusted, there are three GPCIs, each measuring different geographic-based costs:

- The *physician work GPCI* measures geographic differences in the earnings of all college-

educated workers based on census data. It is intended to reflect geographic differences in the cost of living. However, the value of the GPCI for work is reduced because the statute specifies that only one-quarter of the value of work has the GPCI applied to it.

- The *practice expense GPCI* measures geographic differences in medical practice costs as determined by office rent and staff wages. The office rent portion of the GPCI is based on apartment rental data from the Department of Housing and Urban Development, and the staff wages portion of the GPCI is derived from census data. According to the Centers for Medicare & Medicaid Services (CMS), the cost of medical equipment and supplies is virtually the same nationwide, so the practice expense GPCI does not reflect differences in those expenditures.

- The *malpractice GPCI* measures the difference in premiums for a \$1 million/\$3 million policy and is based on actual premium data for each state.

For each component of the fee schedule, the national RVUs are multiplied by the appropriate area GPCI to arrive at the adjusted value for the locality. The three locality components are then added together and multiplied by the national conversion factor. A value for the GPCI of 1.000 yields the national average payment amount. Most GPCIs range from 0.85 to 1.10, or within 15 percent below and 10 percent above the national average.

GPCI components applied to representative surgical services						
CPT/procedures	National		Manhattan, NY		Arkansas	
	Total unadjusted RVUs	Payment	Total adjusted RVUs	Payment	Total adjusted RVUs	Payment
27447 Total knee replacement	41.83	\$1,514.21	51.94	\$1,880.29	36.19	\$1,309.90
33512 CABG, vein, three	52.15	1,887.79	63.45	2,297.02	45.67	1,653.07
35301 Rechanneling of artery	29.32	1,061.36	35.51	1,285.52	25.69	929.80
44140 Partial removal of colon	32.36	1,171.41	38.90	1,408.20	28.71	1,039.17
49505 Repair inguinal hernia	12.38	448.15	14.98	542.20	10.96	396.81
52601 Prostatectomy (TURP)	21.27	769.96	25.79	933.62	18.95	686.04
63047 Removal of spinal lamina	28.64	1,036.75	35.77	1,294.67	24.48	886.28
66984 Remove cataract, insert lens	18.49	669.32	22.48	813.79	16.54	598.65

Note: All payments were calculated for facility settings. Payments for 2002 were calculated using the 2002 conversion factor and final rule values published in the *Federal Register* on November 1, 2001.

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Differences in GPCIs

The table above shows payment amounts from a locality with very high GPCIs (Manhattan, NY) and from a locality with very low GPCIs (Arkansas) to illustrate the differences GPCIs make. Generally, the payments in Arkansas are 70 to 75 percent of what they are in Manhattan. The variation from procedure to procedure occurs, of course, because there are differences in the percentage of payment for work, practice expense, and malpractice. For example, the malpractice expense for code 63047 represents 9 percent of the total RVUs, whereas work for code 66984 represents 2 percent of the total RVUs.

By statute, CMS is required to update the GPCIs with new data every three years, with the most recent update occurring in 2001. However, the GPCIs did not change much because 1990 census data were still used to determine the cost of wages. When the 2000 census data become available, some significant changes may occur in the physician work and malpractice GPCIs. The rent data were updated using data collected in 2000. Malpractice

data, which are always the oldest, were updated using data from the three-year period of 1996 to 1998.

The GPCIs are not perfect, of course. The work GPCI should be based on physician-equivalent data rather than data for all college-educated workers. Apartment rental data are used as a proxy for non-existent medical office rental. Data from the American Medical Association's Socioeconomic Monitoring System (SMS) suggests that geographic differences do exist in the cost of medical equipment and supplies. These limitations in the GPCIs suggest the need for an ongoing survey of physician-specific data.

The development of a geographic adjustment became necessary when a national fee schedule was put into place. There had to be some way to account for the economic differences across geographical regions of the country. The intent behind the current methodology was to provide a fair and equitable way to appropriately compensate those areas of the country with higher costs of living. 

Gowns and drapes for the “level of exposure anticipated”

by Nathan L. Belkin, PhD, Clearwater, FL

The use of surgical gowns and drapes evolved as a standard of practice a century ago.¹ Their primary purpose was to protect the sterile surgical zones from microbial invasion. For the most part, the items were made of a loosely woven, readily permeable, reusable fabric generically known as muslin.

It was not until 1952 that Beck alerted the surgical community to the fact that while the material may have been considered an acceptable bacteriological barrier when dry, it lost its barrier capability once it became wet even when multiple layers were used.² This proved to be the turning point that triggered research into developing more satisfactory materials for this unique application.

It was also during this period that another segment of the textile industry made its presence known, namely, nonwoven, disposable material that was intended to be used once and thrown away. The new generation of materials ignited the heated controversy between reusable and disposable material that completely overshadowed the concern for the patient's welfare and the influence that either might have on the incidence of a surgical site infection (SSI).

Although improved materials were available in both reusable and single-use qualities, for a decade thereafter most hospitals continued to use products made of the traditional, readily permeable, reusable material. Some health care providers simply incorporated the new, more expensive “barrier” quality materials into their gowning and draping practices with the thought that they would perhaps protect their patients from another possible portal of entry for exogenous contamination. However, the popularity of the single-use products mushroomed dramatically when skewed by the provisions of a reimbursement system that permitted all single-use items to be charged to the patient on a cost-plus basis. In addition, having thus been viewed as revenue generators by hospital administrators, whatever clinical benefit to be derived from their use was totally obscured by their financial effects.

Barrier materials and SSI

The latest edition of the Centers for Disease Control and Prevention (CDC) *Guidelines for the Prevention of Surgical Site Infections* cites a number of studies that have been conducted to demonstrate the influence that gowns and drapes made

of the new barrier-quality materials had over the incidence of SSI. However, they state that “there are limited data that can be used to understand the relationship of gown or drape characteristics with SSI risk,” and that “the wide variation in the products and study design make interpretation of the literature difficult.”³ As observed by Birenbaum, their position could well be attributable to the fact that because both the gowns and drapes were made of barrier-quality materials, it is impossible to determine whether it was the gowns, the drapes, or the combination of the two that provided the benefit.⁴

Gown’s protective role

The emergence of the era of the hazards associated with the transmission of blood-borne pathogens dramatically altered the role of the surgeon’s gown. Whereas it had initially been used to protect the patient from the surgeon, its protective capability now focused on protecting the surgeon from the patient.

As mandated by the Occupational Safety and Health Administration’s (OSHA’s) Final Standard on Occupational Exposure to Bloodborne Pathogens and the use of Personal Protective Equipment (PPE), the need for and the function of the surgeons’ gown are now givens.⁵ OSHA’s mandate for its use states that its selection is to be made based on “the duration of time which the protective equipment will be used” and for the “level of exposure anticipated.”

Nevertheless, whether it be for gowns or drapes, the results of the only test methods that the textile industry has developed for testing a material’s “barrier” effectiveness are reported on a pass/fail basis, thereby characterizing it as being impervious or liquid-proof.^{6,7}

It should be noted that although OSHA’s final rule makes no mention of or reference to the surgical drape, the textile industry’s tests have classified it as an item of “protective clothing.”^{8,9} Interestingly enough, the Food and Drug Administration’s code of federal regulations describes the drape as a “protective patient covering...that includes a plastic wound protector that may adhere to the skin around a surgical incision or be placed in a wound to cover its exposed edges....”¹⁰

Be that as it may, reporting the effectiveness of a barrier-quality material on a pass/fail basis liter-

ally prohibits surgeons from selecting the quality of protective products that they believe is required for themselves and their patients for the “level of exposure anticipated,” or what Bernard and Beck referred to as the “usual conditions of use.”¹¹

Questions to answer

What seems to have been overlooked in these rules are the advances made in surgical techniques over the past decade and the variances in draping practices that have accompanied them. For example:

1. With the trend toward small incisions and minimally invasive procedures, how vital is the need for both the gowns and drapes to be made of materials that “pass” the textile industry’s tests for maximum effectiveness?

2. Last year, an estimated 65 percent of surgical procedures performed in hospitals were done on an outpatient basis. That number is expected to increase another 28 percent in the next five years. In addition, there is the corresponding increase that has been projected for the number of procedures performed in physicians’ offices and freestanding ambulatory surgery centers.¹² In these settings, how vital is the need for both the gowns and drapes to be made of costly barrier-quality materials that pass the industry tests?

3. A survey of draping practices found that almost two-thirds of the respondents reported using incise drapes.¹³ If an incise drape is used, why is it necessary for the entire patient drape to be made of barrier-quality material?

4. If the surgical drape is to be considered “protective clothing” for the patient, why shouldn’t its selection be predicated on the same basis as the surgical gown, that is, on the “level of exposure anticipated?”

Influences on SSI

Cruse has astutely observed that, “Endogenous contamination is far more important than all the exogenous factors combined; yet paradoxically, the aseptic religion is aimed at the Satan of exogenous contamination.”¹⁴ Laufman more succinctly identified the major contributing factors to the incidence of SSI and defined them as the “5 Ds”:

1. Discipline of the surgeon.
2. Defense mechanisms of the patient.
3. Drugs—prophylactic antibiotics.

4. Design of the surgical suite.
5. Devices—of which surgical gowns and drapes are but one category of the hundreds of items used.¹⁵

An excellent example of what might be considered the enhancement of defense mechanisms is the recent report in which an international collaboration of 70 investigators in 10 countries concluded that for patients undergoing major operations, supplemental oxygen had the potential to protect them against the incidence of surgical wound infections.¹⁶

A recently published editorial on prevention of surgical wound infections concluded, “The best strategy for preventing not only wound infections but also other complications will involve staff of all types working together during surgery, in the recovery room and postoperatively.”¹⁷

Summary

Today, the intensity of the pressures to not only control but to reduce costs prohibits the luxury of perpetuating any practice simply because “that’s the way we’ve always done it.” Rather it mandates an assessment of the cost-effectiveness of every practice from the perspective of its influence on the outcome of the surgical procedure.

The need for surgeons’ gowns and drapes to be made of a barrier-quality material was first viewed as a reasonable practice. Subsequently, it was assumed that data had been developed to support that need. Actually, their worthiness has yet to be demonstrated through unbiased, statistically valid, conclusive research.¹⁸ Under the circumstances, it could be said that their cost-effectiveness is predicated on what has been described as “anecdotal experience and commercial interests rather than scientific studies.”¹⁹

The question at hand, therefore, is not one of the cost-effectiveness of reusable versus disposable drapes and gowns, but rather one of the surgical community being able to select the products they believe are commensurate with the “level of exposure anticipated” and “under usual conditions of use.” □

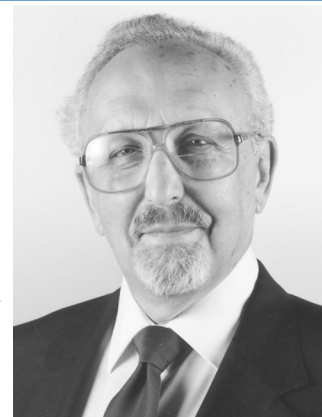
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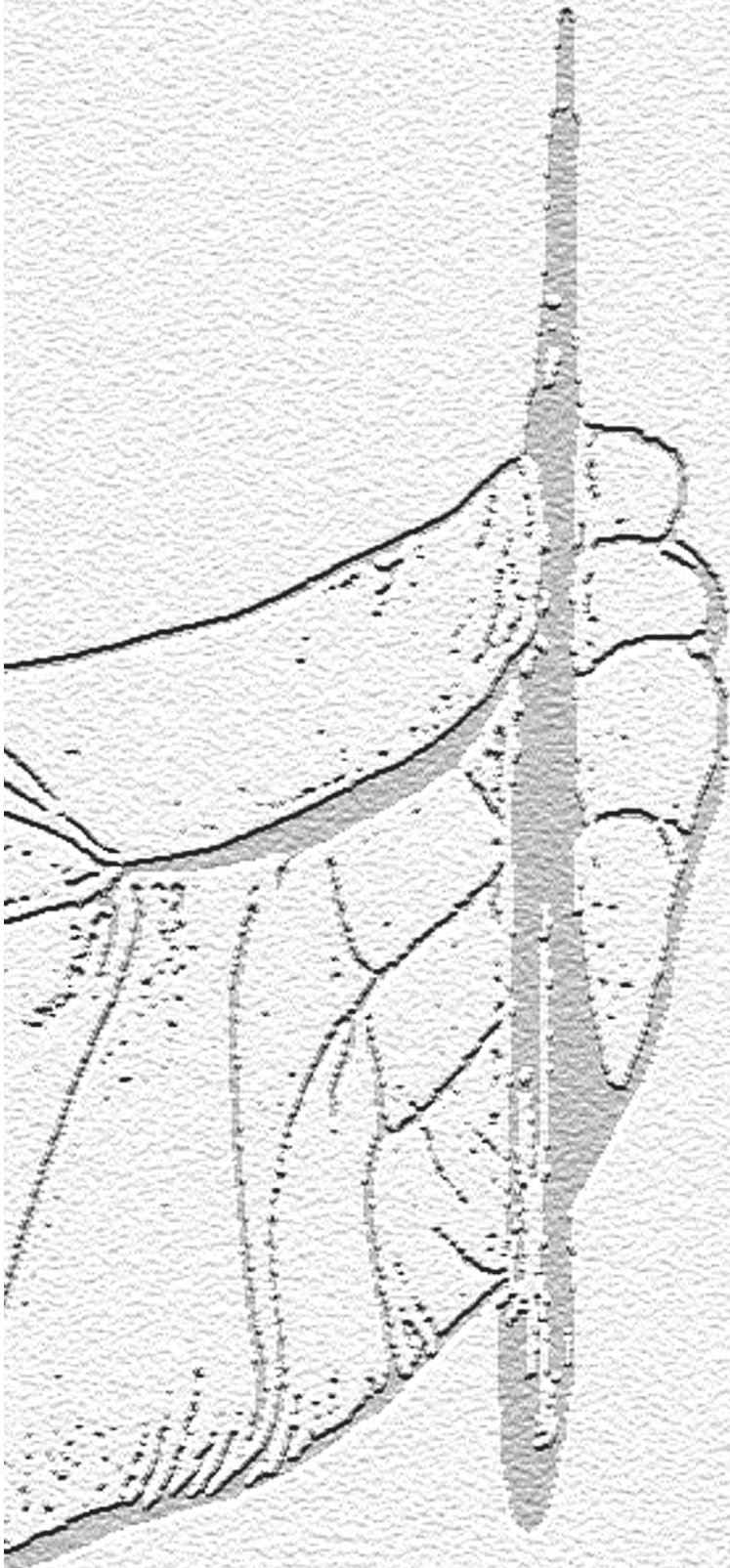
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Dr. Belkin retired in 1991 after a 40-year career in research and development of surgical textiles. He was a charter member of the ad hoc interdisciplinary “barrier” committee (CORE, AORN, and industry), as well as its successor organized under the auspices of the Association for the Advancement of Medical Instrumentation.





What makes a general surgeon

by
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El Dorado, AR

The clock read 4:30 am. I had just returned from the hospital following emergency surgery. The case was a small bowel volvulus with gangrenous bowel requiring resection. The problem had been removed, and the patient was stable and was expected to do well. However, I was too wound up to fall asleep.

Lying in bed, I went over the operation in my mind again, as I had done on so many occasions before. Sleep would be brief. Soon it would be time to begin the day's work. First to check this patient in recovery, then begin elective surgery, making morning rounds between cases. Office hours began at 2:00 pm, and finally evening rounds. If there were no emergency cases, then I could sleep.

My mind reflected back over the years. Why did I choose general surgery, a specialty that requires so much time at the hospital at the most inconvenient hours?

I thought of my family. My wife had raised our three children practically by herself. How different from my schoolmates, who are teachers, lawyers, and bankers, all with work schedules that allow time with their family. At no time did I feel free of call. I couldn't tell a patient to call another doctor. Even though I had very capable partners, I never felt comfortable being unavailable. When I operated on a patient I felt I belonged to them.

I would ask myself, "Would I be happy otherwise?" The answer had to be "no." In my experience, most general surgeons fit the same mold. Are these traits inherent in us, or do we acquire certain characteristics during our training period?

I thought of my training in the 1950s and 1960s. After attending Arkansas Medical School, I served my surgery residency at Confederate Memorial Medical Center in Shreveport, LA. Like most of us during this era, my residency was structured after the Halstedian system, a highly competitive program. Principally a hands-on residency, the basic concept was "see one, do one, teach one." The favorite quote, "You can't learn to play the piano by going to a concert," points to the fact that the best way for a surgeon to learn technique and how to make decisions is through actual experience.

At Confederate, we had no in-house staff, but we did have an excellent visiting staff in the city dedicated to surgical training. These men were there for consultation, conferences, and ward rounds and assisted in surgery if needed. Outstanding residents

also contributed to my education. Surgeons are not born but made through training of both mind and hand, under the guidance of their peers. In this way basic surgical principles are instilled and reinforced. Utilizing consultation with the visiting staff, residents were given the full responsibility for care of their patients.

I well remember my introduction to this seemingly awesome responsibility. The transition was quite a shock for me. I actually threw up on my way to work that first day! It took time to become accustomed to this responsibility, but gradually I learned not only to accept it but to welcome it.

Temperament and judgment

Under this system one must quickly develop the disposition to deal with difficult problems. Charles Knight, MD, chief of visiting staff, told us that while it's important to learn to "cut and sew," it's just as important to learn surgical judgment—sometimes under very difficult circumstances.

Responsibility

Unlike an eight-to-five job, we could never turn it off, go home, and relax. We were responsible at all times to the patient, as well as to the senior resident and visiting staff. I quickly learned the patient takes top priority, no matter what my wife and I had planned for the evening.

Perseverance

In time, I would be fully capable of operating around the clock and being at work the next day, bright and chipper. The old saying, "Exhaustion never excuses a mistake," is true. We learned to think and act even when dead tired. And when I thought I had seen it all, something else would come in that completely shocked me.

Challenges

I'll admit that after 36 hours on call, my passion was my family. Many times I saw emergency cases that made me think, "There but for the grace of God go I." I would look at my loved ones after a night of gunshot and stab wounds and realize how blessed I was.

After a time of tumor service, it seemed everyone I saw outside the hospital had a bad disease. It was difficult not to be overly concerned about my own family. What a relief to realize they were all healthy.

Finally, I had to work to overcome the feeling of helplessness when nothing I could do would save the patient. As physicians, we all have to deal with this in our own way.

An unending process

We never learn surgery. It's a lifelong process of attaining and refining surgical skills, evaluating clinical trials, and learning new trends in diagnoses and perioperative care. Lying there, I wondered if the public realized how many conferences and training sessions a surgeon attends for the sole purpose of keeping sharp and on his or her toes. I wonder how many have the foggiest idea how incredibly complex this business of surgical decision making is and how much sheer accumulated knowledge surgeons have to bring to bear every time they see a patient.

The general surgeon's personality

Benard Jaffe, MD, FACS, professor of surgery at Tulane University, New Orleans, LA, declared, "One thing for certain, Halstedian Pyramids didn't tolerate laziness, poor attitudes, impudence or intellectual mediocrity."* This discipline—combined with the intense responsibility, emotion, and competition common to all surgery residencies—seems to contribute to the personality of the general surgeon. The physical and mental toughness, sometimes mistaken as arrogance and assertiveness, is necessary to accept the challenges of general surgery.

Reflections

If I had it to do over, I would again choose general surgery. Even with the long hours, there are few greater experiences in this life than to perform a successful operation. That's what empowers the surgeon, and the gratification is habit-forming. Surgeons are most happy when they are operating. My best recollections have nothing to do with income. Memories I treasure are challenging cases, maybe in the middle of the night, with a successful outcome.

I believe any time is the "Golden Age of Surgery." The broad knowledge general surgeons acquire, their tenacity, the "hands-on" practice, and the fact that most of their patients get well will appeal to

students in the future as it did to me. As my associate, C.E. Tommey, MD, puts it, "There will always be a demand for the general surgeon. If I am seriously ill or involved in a serious accident, I want a general surgeon around."

It was now almost 6:00 am. Time to get up and begin a new day.

I have difficulty recognizing Confederate Memorial Medical Center today. The name has been changed to Louisiana State University Hospital Shreveport. A medical school, along with a large multistory complex, has been added to the already 1,200-bed hospital. This medical center now has huge operating suites, ICU, CCU, burn units, libraries, administrative offices, classrooms, and many other additions. "There are full-time in-house staffs in all multispecialty areas including cardiovascular, neurosurgery and transplant departments," said John McDonald, MD, chief of surgery.

Yet one thing doesn't change: The training of new surgeons goes on as before. For all the new additions and professors, the residents starting each July are just as green and just as scared as I was. These residents will work just as hard, with as many sleepless nights and as much devotion to the patient as I had when I was there. They will adhere to the work ethic and soon will welcome their "awesome" responsibility. They will develop that special personality and will eventually fit the same mold we've helped to shape. And the work will go on. 

A version of the preceding article originally appeared in the January 2002 issue of *The Journal of the Arkansas Medical Society*. This version is reprinted with permission from the Arkansas Medical Society.

***Dr. Scurlock is a
retired general
surgeon from El
Dorado, AR.***



* Jaffe B: *Surgical Rounds*, July 1998.

In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)—the name alone sounds massive and ominous. Now that many of the regulations associated with the law have been issued and are due for implementation, our best advice to you and your practice administrators is: don't panic. In the coming months, this column will provide a step-by-step guide to complying with the rules established under HIPAA, so you and your staff may discuss and implement the necessary changes in a practical and timely way.

Basics of compliance

HIPAA authorized the creation of specific standards for health care information that is maintained, reported, and transmitted electronically. Now the entire health care industry is changing the way it processes information on computers and the Internet to comply with HIPAA regulations. What does the small to mid-sized surgical practice need to understand for day-to-day operations?

In a nutshell, HIPAA will make all involved parties speak the same language. The same electronic formats and codes will be used by all payors. There will be standard rules on how patient information is maintained in a practice. The question that will become commonplace in many discussions among practice managers is, "Are we HIPAA-compliant?"

Many provisions in HIPAA pertain to what is referred to as "administrative simplification," and the implementation of the various HIPAA standards will become effective on different dates. The three major components of HIPAA that you and your staff need to be aware of are: (1) transactions, (2) privacy, and (3) security. Transaction standards are the first to become effective (October 2002), followed by the privacy standards (April 2003), and finally the security standards (not yet released; compliance will be required 24 months after release).

What you need to do

Implementation of the necessary changes will probably require some expenditures on the part of your practice, and you may have to change some of the ways you currently collect and maintain patient information. More specifically, your compliance efforts will demand review of current forms and the introduction of new required forms. Either you or some of your staff will need to be responsible for privacy activities and any concerns that patients may have about the confidentiality of their health records. You will have to review and update your policy and employee manuals to include the new privacy and security requirements that have been implemented in your practice. The intended purposes of these steps are to reduce the number of resources you will need to record and to report the services you provide to your patients and to ensure the confidentiality of the information contained in their records.

To start the process in your practice, the regulations require you to appoint a privacy officer to oversee compliance implementation. This individual may be a physician or a staff member. Each month, we will offer tips for privacy officers to review to ensure your HIPAA compliance efforts remain on track. □

Next month: *Talking to your vendors.*

ACS guidance on HIPAA issues is based on information contained in the "Small Practice Implementation Guide" (<http://snip.wedi.org/public/articles/smallpractice.pdf>), © 2001, The Workgroup on Electronic Data Interchange.

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery*, including how to save \$20 on a subscription to the online version, is available by visiting www.acssurgery.com/learnmore.htm.

Keep current online

Online access to *ACS Surgery: Principles and Practice* is now only available to paying subscribers. We hope that the extended free-trial period helped you to appreciate the high standards of quality that this College-sponsored resource represents.

As a special member benefit for ACS Fellows, Associates, and Candidates who are not already subscribers to *ACS Surgery*, we are pleased to offer a \$20 discount on subscriptions to the online version of the reference. *You pay an annual subscription fee of \$179, instead of the customary \$199 rate.* Please go to www.acssurgery.com/learnmore.htm for more information and to save \$20 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* continue to receive free online access to the monthly updates and full text by visiting www.acssurgery.com. You will need your nine-digit account number, which may be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing acssurgery@dwweb.net. Updates are also available quarterly through subscription to the *ACS Surgery* CD, which incorporates every online update from the previous three months, and yearly through subscription to the annual hardcover edition of *ACS Surgery*, which incorporates every online update from the preceding year.

II. Care in the ICU

9. *Molecular and Cellular Mediators of the Inflammatory Response*. Vivenne M. Gough, MB, ChB; Constantinos Kyriakides, MD; and Herbert B. Hechtman, MD, FACS. In their new chapter, Drs. Gough, Kyriakides, and Hechtman focus on humoral and cellular responses to injury, making use of several types of clinically significant events to illustrate important inflammatory pathways. This approach is consistent with the history of research into inflammatory response. For example, they note that the significance of neutrophils in the generation of reperfusion injury was first demonstrated in the context of myocardial ischemia. This detailed survey includes information on the mechanisms and functions of the following cell types and molecular mediators: neutrophils; adhesion molecules, including the various selectins, integrins, and immunoglobulins; cytokines, including tumor necrosis factor and the interleukins; activated protein C, which is the basis for a recently approved antiseptic drug called drotrecogin alfa (Xigris); reactive oxygen metabolites; nitric oxide; complements; mast cells; and eicosanoids, including the prostaglandins.

Inflammation is a highly complex process that involves many interacting systems, which may complement each other, antagonize each other, or both. A degree of redundancy is built in, so that antagonism of one pathway may lead to augmentation of another alternative inflammatory mechanism. Furthermore, simultaneous or sequential production of both proinflammatory and antiinflammatory signals often occurs. Accordingly, the success of a therapeutic intervention depends not only on the type of injury or insult present but on the timing of the intervention, as well. Unfortunately, the clinical trials done to date, evaluating a host of antiinflammatory agents of different classes, have been largely disappointing. For more successful therapies to be developed, much more information regarding the fundamental mecha-

nisms of the inflammatory response will be needed. Subscribers may view the full text of “Molecular and Cellular Mediators of the Inflammatory Response” at www.acssurgery.com.

Surgical techniques

12. *Pancreatic Procedures*. John L. Cameron, MD, FACS, and Keith D. Lillemoe, MD, FACS. Dr. Lillemoe has joined Dr. Cameron to revise the chapter on pancreatic procedures. In their description of pylorus-preserving pancreaticoduodenectomy (the Whipple procedure), they start by saying that surgical resection of a periampullary carcinoma can be accomplished by means of either a pylorus-preserving pancreaticoduodenectomy or the classic resection, including an antrectomy. The decision is usually made on the basis of individual surgeon preference, unless there is obvious tumor encroachment on the first portion of the duodenum. Neither approach appears to have a proven advantage in terms of either relative ease of performance or short- or long-term outcome, including survival. In this chapter, Drs. Cameron and Lillemoe focus primarily on the pylorus-preserving modification but also refer to certain important components of the classic Whipple resection.

The other pancreatic procedures covered in this chapter are:

- Distal pancreatectomy for chronic pancreatitis.
- Longitudinal pancreaticojejunostomy (Puestow procedure).
- Drainage of pancreatic pseudocyst into a Roux-en-Y jejunal loop.
- Drainage of pancreatic pseudocyst into stomach.
- Palliative bypass for unresectable pancreatic cancer.

Subscribers may view the full text of “Pancreatic Procedures” at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in 2002 include the following:

- “Outpatient Surgery,” by Richard B. Reiling, MD, FACS, and Daniel P. McKellar, MD, FACS.
- “Open Esophageal Procedures,” by Richard Finley, MD, FACS, and John Yee, MD.

- “Esophageal Procedures: Minimally Invasive Approaches,” by Marco G. Patti, MD, FACS, and Piero M. Fisichella, MD.

- “Emergency Department Evaluation of the Patient with Multiple Injuries,” by Felix Battistella, MD, FACS.

- “Thoracoscopy,” by Valerie W. Rusch, MD, FACS, and Raja Flores, MD.

- “The Elderly Surgical Patient,” by James M. Watters, MD, FACS, and Jacqueline McClaran, MD.

- “Anal Procedures,” by Ira J. Kodner, MD, FACS.

- “Multiple Organ Dysfunction Syndrome,” by John C. Marshall, MD, FACS. 

Mr. Kelly is editor, *What’s New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

A risk management checklist: Part I

Proper risk management is about meeting and fulfilling reasonable expectations for the various elements of the practice, including adequate documentation of the following: medical records; billing and collection guidelines; employee screening, training, and safety; and environmental safety and comfort.

To help practices meet the demands for risk management, we have developed the checklists presented later in this series of columns. (Part II of the series will be published in the June 2002 issue of the *Bulletin*.) The lists are broken down into key areas including documentation of medical records, medications, consent issues, billing and collections, employee files and training, and the practice environment.

Relevance of risk management

Physicians and office staff who are focused on risk management have safer practice environments, maintain better medical records, respond more quickly to emergencies, can assure better medical care, and are at a lower risk of malpractice and other liability.

Patients, employees, other physicians, hospitals, and regulators have come to expect not only minimal compliance for the records and functions of the practice, but have “raised the bar” with regard to what is termed minimal compliance. Physicians must ask themselves what is a reasonable expectation for the various functions of their practices. As technology improves and changes and as the costs for technology decrease, the anticipation of considerable amounts of data becomes the norm. Practices must meet this demand or face the risk of consequent liability.

Good risk management requires that you change your point of view from that of what is reasonable for your practice to what is expected of your practice by others, including patients, lawyers, insurers, regulators, and other physicians.

The best way to determine whether your practice is meeting these demands is to evaluate the materials and processes from your own practice prospectively. This critical review will prepare

Around the corner

May

- ACS-sponsored basic and advanced coding workshops for surgeons on May 23-24, 2002, in Baltimore, MD.*

June

- ACS-sponsored basic and advanced coding workshops for surgeons on June 20-21, 2002, in Atlanta, GA.*

*Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> to register.

you for the closest scrutiny, even if the ones evaluating you are in an adversarial position.

Medical records checklist

- Are entries in the medical record legible, dated, and signed?
- Do you have large gaps in the progress note pages? These discrepancies could increase the probability of entries being out of chronological order.
- Has the physician reviewed and initialed dictated notes that have been transcribed? Are the notes dated?
- Have follow-up instructions been entered into the record? This sort of information may be on the charge ticket (superbill).
- Are missed and cancelled appointments noted in the chart?
- Are test results initialed and dated to indicate they have been reviewed?
- Is there documentation telling patients the results of diagnostic tests?
- Are written reports from consultants initialed and dated?
- Are patient follow-up appointments documented in the record?
- Are patient cultural and religious preferences noted, so that proper decisions regarding blood

transfusions and organ donation can be made?

- Is there documentation of any brochures given to the patient?
- Are there loose papers in the record?
- Are standardized H&P forms initialed and dated?
- Are stamped signatures used? They should not be used.
- Is there a consent to treat form in the record for minors?
- Are referrals to other physicians for consults documented?
- Are all phone calls with patients concerning patient care documented?
- How long are telephone logs maintained? Most insurers want to see 10 years of such registers.
- How are corrections in the clinical record indicated? A single line through the incorrect information signed and dated is preferred.
- Is the corrected note legible?
- What is the procedure for follow-up on missed appointments? Is it documented?
- Is there an examination and medical indication prior to a prescription or dispensing of medications?
- Is patient compliance documented?
- If the physician-patient relationship is terminated during treatment, is it documented?
- If death occurs outside the hospital, does the record indicate how the doctor was notified and who pronounced the death?
- Is there documentation of health directives, such as a durable power of attorney or other state-specific laws?
- Are there documentation and policies on reviewing all advertising and the use of preprinted brochures?
- Does the documentation support the diagnosis? Is the treatment plan consistent with the diagnosis?
- Is there documentation that a chart has been reviewed by the physician prior to archiving?
- Are all X rays read or confirmed by a board-certified radiologist?

Medications checklist

- Are all sample medications dispensed in the office documented in the patient's record?
- Are sample medications securely stored?

- Are expired medications and samples removed?

- Is there a medication list in the record indicating date, refills, discontinued medications, and ordering physician?

- Are telephone prescription renewals properly documented?

- Are all drug allergies documented and easily identified?

- Are all prescription blanks, medications, syringes, and needles stored in a secure location?

- Is there documentation of all supplies given to patients?

- Are proper and required records maintained for controlled drugs (schedules II through V)?

- Are controlled substances inventoried regularly? The law requires that such inventories occur no less than every two years.

Better safe than sorry

Generally, well-run practices are doing the previously described activities on a regular basis. If there is any problem at all, it tends to be with the documentation of the work being done and the timing. The best way to resolve these issues is to have a regular schedule for double-checking to see that each step is being done. It is also a good opportunity to delegate jobs to different people in the practice. Make sure the assignment is one they are qualified to perform and evaluate, and then make sure they report their findings, corrections, and recommendations.

Practices that make safety, security, and good documentation a part of regular patient care minimize the risks associated with a modern practice and create an excellent environment in which to work and be a patient. □

This information originally appeared in "Tips & Techniques," an Internet newsletter published by Economedix, LLC. Tom Loughrey of Economedix provides individual practice management consultations to ACS fellows during the ACS Clinical Congress. All information is © Economedix, LLC, 2002. All rights reserved.

College news

Distinguished chair in trauma surgery named for Dr. Carrico

In recognition of his contributions to the field of surgery and to the University of Texas Southwestern Medical Center at Dallas, the medical center recently established the C. James Carrico, MD, Distinguished Chair in Surgery for Trauma and Critical Care. More than 318 donors, including friends, colleagues, and former residents contributed to a \$1 million endowment to establish the distinguished chair—only the second in trauma named in the entire country.

“This distinguished chair is a contribution to [the University of Texas Southwestern Medical Center],” Dr. Carrico said during a reception in his honor, which took place in March and was attended by those individuals who contributed to the endowment. “Long after we are gone, the endowment will continue to support the activities of trauma research and education.”

During the reception, Robert Rege, MD, FACS, who succeeded Dr. Carrico as chairman of surgery at the University of Texas Southwestern Medical Center at Dallas, paid tribute to Dr. Carrico’s many contributions to the ACS, noting his leadership during the College’s period of reorganization. Dr. Carrico is President-Elect of the College and is the immediate Past-Chair of the Board of the Regents.

Dr. Carrico served as chair of the department of surgery at the



Dr. Carrico (right) receives a plaque from Dr. Rege during a Feb. 21 reception at the A.W. Harris Alumni-Faculty Center. Later Dr. Wildenthal (left) gave Dr. Carrico a chair that symbolizes the endowed chair that bears his name.

University of Texas Southwestern Medical Center at Dallas from 1990 to 2001, and his colleagues attribute him with revitalizing the department and guiding it to its current prestigious position. Kern Wildenthal, MD, president of the institution, said that during his time as chair of surgery there, Dr. Carrico helped strengthen the department by recruiting key faculty from other institutions and retaining excellent residents. “His dedication to educa-

tion, research, and clinical care was instrumental in the growth and evolution of the department,” Dr. Wildenthal added.

Dr. Carrico currently serves as the Doris and Bryan Wildenthal Distinguished Chair in Medical Science and professor, department of surgery, at the university medical center.

Distinguished career

Dr. Carrico’s career in medicine and surgery has been illustrious. As a graduating medical

student at the University of Texas Southwestern Medical School at Dallas, he received the Ho Din Award, the top prize awarded by the Southwestern Medical Foundation to a student. He subsequently performed his research fellowship at the medical school under the direction of G. Tom Shires, MD, FACS. Dr. Carrico completed his internship and residency at Parkland Memorial Hospital in Dallas. After finishing his residency, Dr. Carrico served in the U.S. Navy and established the shock unit at San Diego Naval Hospital.

From 1969 to 1972, Dr. Carrico was assistant professor of surgery at the University of Texas Southwestern; he served as an associate professor of surgery at that institution from 1972 to 1974. Dr. Carrico then ventured to the northwest portion of the country to work at the University of Washington School of Medicine in Seattle. While there, he served as an associate professor of surgery from 1974 to 1976, a professor of surgery from 1976 to 1990, and chairman of the department of surgery from 1983 to 1990, when he returned to the University of Texas Southwestern.

In addition to serving as the Chair of the Board of Regents

and as President-Elect, Dr. Carrico has been active in a number of leadership roles within the College since he became a Fellow in 1971. He became a Regent in 1992. He currently serves on the Finance Committee, the Ad Hoc Committee on Verification, and the Honors Committee. In the past he has been active on the Committee on Continuing Education, serving as its Vice-Chair from 1984 to 1986 and on its SESAP IV and V Committees from 1980 to 1982 and 1982 to 1984, respectively.

Dr. Carrico served on the Board of Governors from 1984 to 1990 and was its Chair from 1989 to 1990. In addition, he chaired the Program Committee from 1995 to 1999. He served on the Pre- and Postoperative Care Committee from 1975 to 1983, serving on the Executive Committee of the latter body from 1978 to 1981.

Given his emphasis on burn, trauma, and critical care, Dr. Carrico has been particularly involved with the College's trauma program. He was a member of the Committee on Trauma from 1982 to 1992 and served as Vice-Chair of its Executive Committee from 1986 to 1989. Dr. Carrico also chaired the Wash-

ington State Committee on Trauma from 1979 to 1982 and Region X from 1982 to 1990.

In addition, Dr. Carrico has been very active at the chapter level. He served as President of the Washington State Chapter from 1989 to 1990 and as President of the North Texas Chapter from 1996 to 1997.

He is a member of numerous other medical and surgical organizations, as well, including the American Association of Surgery of Trauma, of which he was president from 1992 to 1993. Dr. Carrico also holds membership in the American Surgical Association, American Trauma Society, scientific research society of Sigma Xi, Surgical Infection Society, Society of University Surgeons, and Société Internationale de Chirurgie.

A prolific author of clinical articles, Dr. Carrico currently serves on the editorial boards of *Annals of Surgery* and *World Journal of Surgery*.

In addition, Dr. Carrico served on the Injury Research Grant Review Committee of the Centers for Disease Control and Prevention. He is a senior member of the American Board of Surgery (ABS) and was president of the ABS from 1992 to 1993.

GOWNS AND DRAPES, from page 22

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Membership in the American College of Surgeons



Here's why it's important:

As a body representing all of surgery, the College:

- Provides a cohesive voice addressing societal issues related to surgery.
- Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
- Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
- Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

There IS strength in numbers.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College's agenda for the future.

If you aren't a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

Here are some of the many benefits being a member of the College affords you:

- Free registration at the Clinical Congress and annual Spring Meeting
- Access to the College's free coding consultation hotline
- ACS NewsScope, the College's weekly electronic newsletter
- *The Bulletin of the American College of Surgeons*
- *The Journal of the American College of Surgeons*
- Access to all College-sponsored insurance, credit card, collection service, and other helpful programs
- Access to the College's free job and resume data bank

Information on becoming a member of the College and an application form are available online at: <http://www.facs.org/dept/fellowship/index.html>(.) Or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 312/202-5284, or via e-mail at chicks@facs.org.



A short history of women surgeons in the College

by Susan Rishworth, Archivist

Women have been Fellows of the American College of Surgeons since its origin. Florence West Duckering, MD, FACS, of Boston, MA, was elected to membership in 1913 and found the officers, Franklin Martin, MD, FACS, first General Secretary of the College, and John Finney, MD, FACS, first President, friendly and kind to her. She was born in Sussex, England, in 1869 and studied nursing in London at a time when the antiseptic treatment of surgical wounds was being introduced. Before then many patients were lost. This advance may have inspired her in later years to specialize in surgery.

First women Fellows

Dr. Duckering left England for the U.S. in 1895, became a natu-

ralized citizen, and entered Tufts College Medical School in Boston where she graduated cum laude. Her niece and namesake, Florence W. Duckering, became a physician in 1937 and was elected to Fellowship in ACS in 1950.

Lillian K. P. Farrar, MD, FACS, was elected to the College in 1915 and served five three-year terms on the Board of Governors from 1925 to 1947. She was born in Newton, MA, and received her medical degree at Cornell University in 1900, where she was an assistant professor in obstetrics/gynecology (ob/gyn) from 1918 to 1935.

Dr. Farrar studied ob/gyn in Paris, France, and Vienna, Austria, and is credited with establishing internships for women at

Bellevue Hospital in 1914 and Woman's Hospital in 1920. She was an enthusiastic member of the College's Committee on the Library and donated many materials on the history of surgery and of women in surgery.

Agnes C. Vietor, MD, FACS, was elected a Fellow in 1916 and served on the Board of Governors from 1925 to 1937. Dr. Vietor edited *Women's Quest*, the autobiography of Marie Zakrzewska, one of the early pioneer women physicians in the U.S. from the 1850s.

Both Drs. Farrar and Vietor saw the importance of recognizing the women who had gone before them and paved the way for their success. Autobiographies of early women physicians, such as *Women's Quest*, show the



Dr. Daily



Dr. Gardner



Dr. Morani

Prominent Fellows

A partial list of historically prominent women Fellows includes the following surgeons (dates indicate year of induction in the American College of Surgeons):

- Ray K. Daily, 1925, voted “medical woman of the year” by American Medical Women’s Association (AMWA), 1960; member of ACS Committee on Library 1948-1960 (see photo, p. 34).
- Mabel E. Gardner, 1926, received AMWA Elizabeth Blackwell Medal and Otterbein College (Ohio) Distinguished Alumni Award (see photo, p. 34).
- Ruth Jackson, 1944, inventor, author of *The Cervical Syndrome*.
- Ruth Kerr Jacoby, 1964, neurosurgeon.
- Elisabeth R. Larsson, 1942, held 18 surgical association memberships.
- Alma Morani, 1941, first woman admitted to American Society of Plastic and Reconstructive Surgeons, member of 11 surgical societies (see photo, p. 34).
- Isabel M. Scharnagel, 1944, first woman admitted to the Bellevue advanced post-graduate course in surgery, and first woman admitted to surgical staff at Memorial Hospital (see photo, this page).
- Ida Scudder, 1935, wrote *Dr. Ida*, a memoir.
- Pearl M. Stetler, 1924, Chicago obstetrician.
- Bertha Van Hoosen, 1922, started AMWA, wrote *Petticoat Surgeon*, a memoir.
- Augusta Webster, 1939, won leadership honor (see photo, this page).



Dr. Scharnagel



Dr. Webster

great odds facing women in their medical school studies and how they overcame great difficulties and resistance on the part of male physicians and sometimes even other women.

Other early leaders

Other women serving on the Board of Governors in the early years were Alice F. Maxwell, MD, FACS; Jean P. Pratt, MD, FACS; Julia C. Strawn, MD, FACS; and Emma K. Willits, MD, FACS.

Dr. Maxwell graduated from the University of California Medical School in 1915, where she served as associate clinical professor and authored numerous publications in her specialty of ob/gyn. Dr. Willits graduated from Women’s Medical College of Chicago, IL, in 1896 and helped to develop the Children’s Hospital in San Francisco, CA. There she served as chief of children’s surgery from 1910 to 1918 and chief of staff in women’s and children’s surgery

from 1918 to 1934. Eventually, she ascended to the chairmanship of the department of general surgery.

In 1951 there were 150 women Fellows in the ACS. Today, there are close to 4,000. In 1970 only 11 percent of all medical students were women and only 1 percent of surgical residents were women. Today, just 32 years later, 45 percent of all medical students are women, and 21 percent of surgical residents are women.

Send information

The College Archives contains biographical files on many other notable early women members of the ACS. We are seeking more information about women Fellows who should be represented in this collection. Interested readers should contact Susan Rishworth, College Archivist, at College headquarters, tel. 312/202-5270, e-mail srishworth@facs.org, for further information.

No Second Opinion Needed.



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Faculty Research Fellowships awarded by College

Ten American College of Surgeons Faculty Research Fellowships for 2002 were awarded by the ACS Board of Regents in February. The two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry grants of \$40,000 per year from July 1, 2002, through June 30, 2004. The recipients are:

Alan Dardik, MD, PhD, assistant professor, Yale University School of Medicine, New Haven, CT, and St. Mary's Hospital, Waterbury, CT. Research project: Regulation of Endothelial Cell Proliferation and Migration by Hemodynamic Forces. Dr. Dardik's fellowship—the Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons—is named to honor Dr. Martin, founder of the College, and is funded by the Scholarship Endowment Fund of the College.

John H. Yim, MD, assistant professor, University of Pittsburgh (PA). Research project: Interferon Regulatory Factor-1 Induced Tumor Suppression in Breast Cancer. The fellowship is funded by the Scholarship Endowment Fund of the College.

Maria T. Millan, MD, assistant professor, Stanford University. Research project: Epstein Barr Virus Induces Antiapoptotic Factors in the Vascular Endothelium and Protects Against Uncontrolled Activation and Apoptosis. The



Dr. Dardick



Dr. Yim



Dr. Millan



Dr. Austin

fellowship is sponsored by the Scholarship Endowment Fund of the College.

Paul F. Austin, MD, assistant professor, Washington University, St. Louis, MO. Research

project: The Regulation of Bladder Smooth Muscle Proliferation in Response to Stretch. The fellowship is sponsored by the Scholarship Endowment Fund of the College.



Dr. Molmenti



Dr. Foster



Dr. McKee



Dr. Yang



Dr. Desai



Dr. Bathe

Ernesto P. Molmenti, MD, associate professor, Johns Hopkins University School of Medicine, Baltimore, MD. Research project: Proteomic Characterization of Renal Transplant Rejection Using Surface Enhanced Desorption/Ionization (SELDI) and Chip Technology. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Robert D. Foster, MD, assistant professor, University of California, San Francisco. Research project: Costimulation and Hematopoietic Stem Cell Chimerism in Peripheral T-Cell Tolerance to Composite Tissue Allografts. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Mark D. McKee, MD, assis-

tant professor, University of Chicago (IL). Research project: Engineering CEA Reactive Lymphocytes through T-Cell Receptor Gene Transfer. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

George P. Yang, MD, instructor, Stanford University Medical School. Research project: Role of Angiogenesis in

Wound Healing. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Tina R. Desai, MD, assistant professor, University of Chicago (IL). Research project: The role of IL-6 in Hypoxic Endothelial Barrier Dysfunction. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Oliver F. Bathe, MD, MSc, FRCSC, assistant professor, University of Calgary. Research project: Tumor Immunity versus Autoimmunity following Cellular Immunotherapy. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

The Scholarship Endowment Fund of the American College of Surgeons was established in

1965 to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are invited. Fellows interested in making gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376.



ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

College readies Clinical Congress program schedule for San Francisco

The 88th Annual Clinical Congress of the American College of Surgeons will be held October 6-10, 2002, at the Moscone Convention Center in San Francisco, CA. The complete Program Planner for the Clinical Congress will be mailed to all Fellows, Initiates, Associate Fellows, and Candidate Group members in June 2002.

If you are not a member of the College and would like to receive a copy of the Program Planner via mail, please send your complete mailing address to jsmith@facs.org. The Program Planner will be posted online in June. Online registration for the Congress and housing reservations will be available once the Congress program is posted.

For more information and updated program highlights, visit the College Web site at www.facs.org.

Program highlights

- *Named lectures presented by renowned surgeons:* Scheduled lecturers include Haile T. Debas, MD, FACS; Thomas B. Ferguson, MD, FACS; Roger S. Foster, Jr., MD, FACS; Ernest E. Moore, MD, FACS; Seymour I. Schwartz, MD, FACS; James C. Stanley, MD, FACS; Thomas E. Starzl, MD, PhD, FACS; and John Wong, MBBS, FACS (Hon).

- *Sessions on contemporary topics,* such as: Image-Guided

Surgery: From Technology to Patient Care; The M & M Conference—Patient Safety and Error Reduction; The New Member of the OR Team: The Surgical Robot; Stem Cells in Clinical Practice; The Scope of Practice and Future of the General/Trauma Surgeon; Knowledge at the Point of Care: Hand-Held Computing for Surgeons; Radio-Guided Surgery; Heroes: The Influence of Role Models in Career Choice; Programa Hispanico; Advances in Pancreatic Care; Artificial Heart as Destination Therapy; From Competence to Virtuosity; Should Axillary Dissection Be Abandoned?; Bioterrorism; Ethics and the Entrepreneurial Surgeon; and Bariatric Surgery.

- *Multidisciplinary sessions:* Complications of Abdominal Surgery: Getting Out of Trouble in the OR; Perioperative Care of the Diabetic Surgical Patient: Optimizing Outcome; New Modalities in the Diagnosis and Management of Major Vessel Injury; Abdominal and Pelvic Radiation Injuries: Best Practices; Abdominal Organ Transplantation and Update: State of the Art.

- *Specialty sessions:* Advances in Minimally Invasive Surgery for Thoracic Disease; Ileal Pouch and Anastomosis (Restorative Proctocolectomy); Stereotactic Radiosurgery; Transfer of the Intracranial Ex-

perience; Recurrent Thyroid Cancer Evaluation and Treatment; Ultrasound and Cross-Sectional Imaging—Gynecologic Procedures; Cryptorchidism—Current Concepts and Management; Telemedicine and Plastic Surgery; Prostate Cancer; and New Technical Approaches to Venous Surgery.

- *Skills-oriented postgraduate courses:* Ultrasound (breast, abdomen, head and neck, vascular, the acute setting, teaching skills); image-guided and stereotactic breast biopsy; lymphatic mapping; coding; computers; and surgery education.

- *Didactic postgraduate courses* on subjects such as: diseases of the breast, liver, biliary tract, pancreas, and gastrointestinal tract; minimal access surgery; endocrine, thoracic, vascular, cardiac, colorectal, breast, pediatric, and plastic surgery; trauma; surgical infections; professional liability; and urology review.

- *Additional activities:* Video-based education—more than 120 videos and films; more than 300 papers presented in the Surgical Forum and Papers Sessions; technical exhibits from approximately 300 companies; and more than 150 scientific exhibits.

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<http://www.facs.org/commerce/2002/catsplash.html>

For immediate service, browse and order titles online and place your order by credit card through a secured Web server. Or print out your own paper copy of the catalog—and its corresponding order form—and send in your order by mail or fax.

As new titles are added throughout the year, the online catalog will be updated immediately. It's fast, easy to browse, and always up-to-date, the *2002-2003 Publications and Services Catalog*.



Resident Research Scholarships for 2002 awarded

Six American College of Surgeons Resident Research Scholarships for 2002 were awarded by the ACS Board of Regents in February 2002. The scholarships are offered to encourage residents to pursue careers in academic surgery, and carry awards of \$30,000 for each of two years, beginning July 1, 2002. The recipients are:

Kathleen G. Raman, MD, MPH, resident in surgery, University of Pittsburgh (PA). Research project: Prevention of Intimal Hyperplasia in a Model of Atherosclerosis with iNOS Gene Therapy. The scholarship is sponsored by Wyeth Pharmaceuticals.

Randell P. Nacamuli, MD, resident in surgery, University of California San Francisco-East Bay. Research project: Molecular Mechanisms of Cranial Suture Fusion. Dr. Nacamuli's research will be conducted at Stanford University. The scholarship is funded by the Scholarship Endowment Fund of the College.

Todd V. Brennan, MD, resident in surgery, University of California, San Francisco. Research project: Achieving Immune Tolerance with Dendritic Cells. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

Larisse K. Lee, MD, resident in surgery, Harvard University (Massachusetts General Hospital). Research project: The Role of RAGE in Diabetic Atheroscle-



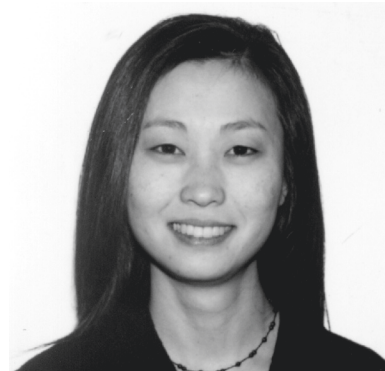
Dr. Raman



Dr. Nacamuli



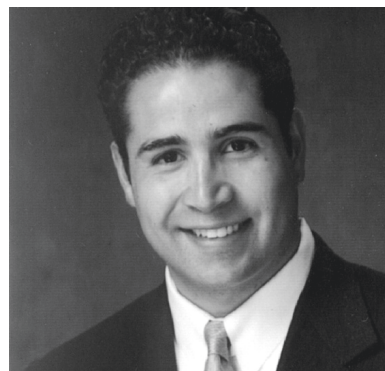
Dr. Brennan



Dr. Lee



Dr. Shen



Dr. Rodriguez

rosis and Arterial Injury. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

Wen Shen, MD, resident in surgery, University of California, San Francisco. Research project: Antiproliferative and Redifferentiating Effects of Combination Therapy with

Retinoids and PPAR-gamma Agonists in Thyroid Cancer. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

Filiberto Rodriguez, MD, resident in surgery, Stanford University. Research project: Mechanisms of Chronic Ischemic Mitral Regurgitation.

The scholarship is sponsored by Ethicon, Inc.

Further information regarding the scholarships, fellowships, and awards offered by the College for 2003 was published in the January *Bulletin* and appears on the College's Web site, www.facs.org.

2002 Oweida Scholar named

Caren E. Gaines Wilkie, MD, FACS, Gallup, NM, was selected to receive the 2002 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The \$5,000 award subsidizes attendance at the an-

nual Clinical Congress, including postgraduate course fees. The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides.

The Oweida Scholarship is awarded each year by the Executive Committee of the Board of Governors.



Dr. Wilkie

Head and neck oncology award presented

The first Faculty Career Development Award for Oncology of the Head and Neck was granted to Robert L. Ferris, MD, PhD, assistant professor of otolaryngology, University of Pittsburgh (PA), for his research project entitled "Cellular Immune Response to p53 in Response to Oncologic Therapy."

The purpose of the award is

to provide support for clinical basic science, or translational research in the study of neoplastic disease of the head and neck.

This new award is jointly sponsored by the College and the American Head & Neck Society at a level of \$40,000 per year for each of two years.



Dr. Ferris

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Letters

The following comments were received in the mail or via e-mail regarding recent articles in the Bulletin and the "From my perspective" columns written by ACS Executive Director Thomas R. Russell, MD, FACS.

Surgical residencies

As a 1998 graduate of a general surgery training program in New York State, I read Dr. Michael Zinner's discussion of surgical training in the *March Bulletin* with some interest. For the most part, my program followed New York state regulations regarding hours worked quite closely, and I believe this only strengthened our residency experience. My training was rigorous, and expectations were high. However, we also had time to read and to do clinical research. We could stay awake through grand rounds and other teaching conferences. And, yes, we could have some time to spend outside the hospital with family, friends, and other pursuits now and then.

A busy training program has plenty of pathology to be seen over the course of five years, and one need not spend every other night on call to obtain a wide exposure to surgical disease. If the concern is "continuity of care for one's own patients," this has far more to do with the pre- and postoperative outpatient care than it does with physically being in the hospital. As for the concern over "hand-offs," those of us in private practice (the majority of surgeons) sign out to partners or colleagues on a regular basis. No one is on call every day, all day, and residents need not be either. I agree that limiting working hours (which should have been done by the programs long ago, without legislation) is only part of the answer. The biggest change needs to occur in the attitude of surgeons themselves regarding how best to train the next generation.

Eric D. Lederman, MD, FACS

Hepatitis C virus

The recent article "Lessons from an HCV-infected surgeon" in the *March Bulletin* raises many issues that should concern all surgeons. For what it is worth, I present my experience in two areas: Prevention of sharp injuries, and potential disability insurance problems for a hepatitis- or HIV-infected surgeon.

I am now retired. I practiced in a community where there were a large number of HIV- and hepatitis-infected patients. Intravenous drug use was the origin in most cases. I was frequently called upon to operate upon these patients. I developed a personal protocol for operating room and office procedures. In many years of use, there was not one sharp injury.

The approach was to prevent contact between anyone involved and a potentially contaminated sharp object. The technique was used selectively. A medical waste container was placed within reach of the surgeon. Any sharp object was dropped into the container immediately after use. If local anesthesia was used, the syringe and needle were used only once. A second syringe and needle were used if necessary. Blunt electrocautery was used for most incisions. If a scalpel was necessary, it was used for one pass and immediately discarded. After placement of a suture, the sledged needle was cut off and dropped into the container. Most knots were instrument ties.

The same approach was used for disposable laparoscopic trocars. At the conclusion of the procedure the container was sealed and disposed of as medical waste. Universal precautions were also followed. While this approach added time and expense, I felt it to be worthwhile because it was almost foolproof.

There have been extremely few documented cases of patient-to-surgeon transmission of HIV in spite of thousands of needlesticks

involving HIV patients. There have been few if any cases of transmission of HIV from surgeon to patient. Hepatitis transmission from patient to surgeon and vice-versa has been a more frequent event. The mechanism of transmission, while often a sharp injury or break in technique, has not always been clear.

Following the case of a young Florida woman and several other patients who presumably contracted HIV from a dentist, Congress mandated that the CDC provide guidelines to the states to prevent this from happening again. These guidelines would effectively prevent a surgeon from performing "invasive procedures." Further, all patients would have to be notified that the surgeon was HIV positive. This alone would effectively end a surgeon's practice. Limitations on hepatitis-infected surgeons arise from hospital or department policies or voluntary cessation for fear of infecting a patient.

In either case, a surgeon would be precluded from practicing while being physically able to do so.

At the time, I made inquiries of several disability insurance carriers, asking whether or not they would pay a claim under these circumstances.

Several agents advised that they thought a surgeon could collect. Responses from the insurance companies were noncommittal, and suggested that they would not pay. One agent suggested that a claim for psychological impairment would be successful. The only positive response was from a large worker's compensation carrier. The carrier advised that a claim would be paid if the surgeon was eligible for worker's compensation. They had not had such a claim at that time.

I did not check Medicare disability. It is my understanding that recent disability policies address this

issue and will not pay unless there is an actual physical disability.

The ACS Long-Term Disability Plan goes a long way toward addressing the problem. The AMA offers a specific HIV policy. All surgeons would be wise to review their disability insurance coverage.

One final point. Needlesticks and breaks in technique are usually well documented in the OR. This is not always the case in the emergency room.

They are almost never recorded in the office setting. This situation could and should be corrected.

The ACS is to be commended for publishing this article. Further attention to these issues by the College would appear to be in order.

Lorne C. Smith, MD, FACS

Health care reform

Accelerating malpractice costs, declining reimbursements, increasing educational debt, and decreasing applications for medical school and general surgery training are all connected and related to a fragmented health care system betrayed by greed. Greed on the part of organized medicine, private insurers, and the pharmaceutical industry has resulted in not only major challenges to our profession but obstacles for patients to access quality affordable care with the freedom to choose their physician, make medical decisions without outside interference, or the ability to access a physician report card.

Incremental reform has been a disaster for patients and physicians, but a blessing for the drug industry and HMO chief executive officers. Countries with national health insurance avoid many of these problems and do not experience the malpractice crisis that resurfaces periodically and painfully.

Furthermore, France and Germany, with their own forms of universal health care, have eliminated waiting lists and now accept overflow patients from their neighbors.

Our profession needs leaders who have the vision to think and act outside the box and constraints of archaic policies.

Jerry Frankel, MD, FACS

In response to Dr. Russell's comments in the February *Bulletin*: I am a general surgeon in Charleston, SC. I have just returned from taking a year off from my practice to help start a local pilot program to help address our health care system's problems, starting with providing care for the uninsured. I was asked to present our program and discuss the needs of our country's uninsured at the College's meeting in New Orleans this past fall with 19 other programs from around the country. The purpose was to assist the College in developing a response to the problem of providing care to the more than 40 million uninsured people in the U.S.

Unfortunately, all of the other programs that were presented were charity programs designed to care for people for free (our program is setting up to pay for services). I mentioned that I thought that the problem was not that we did not provide enough free care but that we had a system that does not provide access to health care for many of our people. I challenged the group to begin developing a new system to address these needs but the response was essentially that this is too big an undertaking and that we should wait to see what the government and private sector do and then react to the situation.

Your final words seemed to echo that sentiment by stating that the ACS will be "closely monitoring all of these issues and will respond appropriately."

I feel that we as physicians need to become more involved with the development of a new system that will allow us to become our patient's advocates again. We are

the only ones who can develop the system that will take the best care of our patients. We are trying to do just that with our pilot program here and will be looking to expand our program statewide in the future if we are successful. Obviously, to move this proposal we will need the support of the medical establishment, including the ACS. I hope you will consider becoming more proactive instead of reactive.

Casey Fitts, MD, FACS

Dr. Russell, I enjoy reading your monthly editorial comments. Regarding the topic of insurance reform, I wish to disagree with the tone or implications of your comments in the February *Bulletin*. You are probably correct that "most players certainly can agree..." or "most people and organizations agree that the health insurance system should be reformed to ensure medical coverage for all Americans..."

Most of my acquaintances would agree that it would be desirable for everyone to have insurance. They do not, however, agree that health insurance for all should be mandated by, subsidized by, or provided by government and taxation.

I firmly oppose government health insurance for the general citizenry. Medical care is an important service in our country, but not one that should be provided through the government. Most of the people I know would agree. I think the tone of your editorial incorrectly implies that there is general acceptance of the idea of deeper government involvement in private medicine.

Sutton L. Graham, MD, FACS

Liability reform

The medical liability reforms supported by the ACS (as described by Christian Shalgian in the February *Bulletin*) are measured, sensible, and lawyerly.

But our efforts to influence the legislators in Congress might be enhanced if they were combined with a substantial, forthright campaign aimed at the public. We should explain in plain language these points: that a system in which the cost of an insurance premium exceeds a surgeon's entire annual income cannot survive; that jury awards are meant to compensate malpractice victims, not amount to lottery jackpots; that this compensation should go to patients and not be dissipated in lengthy legal battles; that medical misadventures occur despite a surgeon's best efforts and not because of them; and that the present system, if unchecked, will lead to a dangerous shortage of surgeons.

Also, the ACS might propose some practical, intuitive solutions

that would appeal to people's common sense. For example, separate the cost of malpractice from the surgical fee and have the cost of insurance paid for, on a case-by-case basis, independently, in the manner of flight insurance.

Adoption of a no-fault policy would further decrease costs substantially, as it has in auto insurance. Furthermore, awards should be paid out according to a uniform standard such as the model used in determining loss in worker's compensation awards.

Finally, initial screening of all potential suits should be carried out by independent professional panels composed of judges and medical experts. These panels should be allowed to decide the presence of negligence based on a systemic informed review of the facts in each case and to recom-

mend whether a case should be dismissed or proceed to trial in a court of law. This method would ensure that both the surgeon and patient are dealt with justly.

George Saj, MD, FACS

American medicine

An excellent summary in the January *Bulletin* of some of American medicine's current dilemmas, Dr. Russell. It is unfortunate that the reimbursement arm cannot keep up with the demand for novel therapies, innovative technology, and sophisticated pharmaceuticals developed by the research arm. Add to this the escalating premiums of liability insurance that these advances have stimulated, and the problem seems overwhelming. Good luck and hang in there.

Robert Turner, MD, FACS

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FDA recalls all A&A Medical ob/gyn and surgical products

The FDA Center for Devices and Radiological Health recently notified health care professionals that all medical devices manufactured by A & A Medical, Inc., of Alpharetta, GA, labeled as sterile and shipped na-

tionwide since 1999, have been recalled because they may not have undergone sterilization. As a result, these devices could cause serious and possibly life-threatening infections.

The recall includes, but is not

limited to, curettes (flexible and rigid), uterine dilators, fetal blood samplers, and laparoscopy accessories. For a current list of known products affected by this recall, visit <http://www.fda.gov/cdrh/safety/safety031502.html>.

Next month in JACS

The June issue of the *Journal of the American College of Surgeons* will feature:

Original Scientific Articles:

- Perioperative Risk Factors for Posterior Ischemic Optic Neuropathy
- Early Debridement for Necrotizing Pancreatitis: Is It Worthwhile?
- Bleeding Esophagogastric Varices from Extrahepatic Portal Hypertension: 40 Years' Experience with Portal-Systemic Shunt

Collective Reviews:

- Surgical Care in Space
- Radiofrequency Ablation of Unresectable Primary Liver Cancer

Ethics

- Ethical Regulations for Innovative Surgery: The Last Frontier?

